

Health Psychology *in* Nursing Practice

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1 WHY NURSES, MIDWIVES AND HEALTH VISITORS NEED HEALTH PSYCHOLOGY

Key Learning Objectives

At the end of this chapter you will be able to explain:

- What evidence-based practice is
- Health psychology and how it can help us as nurses, midwives or health visitors
- Theories of health and health behaviour change – these include:
 - The biomedical model
 - The biopsychosocial model
 - The health belief model
 - Theory of planned behaviour
 - Transtheoretical model
- How health psychology models can inform holistic and person-centred care
- The case for physical versus mental healthcare
- Health psychology and person-centred care

INTRODUCTION

Across all age groups and conditions, nurses, midwives and health visitors are helping patients and their relatives to adjust to diagnoses, to cope with treatment regimens and other disease-related life changes, to manage symptoms and to make healthy choices.

This book takes an evidence-based approach to inform and explore how **health psychology** theories and techniques are useful to us as clinicians in this work. Throughout the book, practical examples of health psychology in action will be given for you to relate to your practice. Research evidence will be critically appraised so you can decide if a particular health psychology approach will help you and your patients.

This chapter will provide an overview of what is meant by ‘health psychology’ and how it informs the way we deliver holistic and person-centred care. The health psychology theories described in this chapter will be referred to in further chapters.

EVIDENCE-BASED PRACTICE

First a word about what research evidence is. For determining the effectiveness of an intervention, it is well established that randomised controlled trials (RCTs) provide the best evidence concerning whether or not an intervention works. This is because of their ability to control for bias and for both known and unknown variables which may have an effect on outcomes above and beyond the intervention being tested.

However, any trial has the potential for bias (e.g. through problems in the way it is conducted) and there may be many variables which cannot all be considered by an individual trial. Hence systematic reviews of RCTs which identify, appraise and bring together, or ‘synthesise’, all available RCTs are likely to provide the most useful and concise evidence for clinicians: in a well conducted systematic review the evidence is critiqued and all available evidence is brought together to save you reading through multiple papers. In this book, when considering whether an intervention works or not, systematic reviews of RCTs will be presented as the first line of evidence and individual RCTs only cited where there is no systematic review or when the search date of the latest systematic review was so long ago that the review may be out of date.

When interpreting a body of evidence, it is important to remember that a finding of weak evidence or of a lack of evidence is not the same as a finding of no effect. That may sound obvious, but it is important to be clear that a lack of evidence simply means that insufficient, good-quality trials have been conducted to determine whether or not an intervention works. A finding of no effect, on the other hand, would result from good-quality trials demonstrating that an intervention did not work. When confronted with a lack of evidence, or evidence that is weak, we have to apply our clinical judgement and think critically whether or how a particular theory or intervention may be useful to us in our clinical practice. This is the science and art of evidence-based practice.

Of course, RCTs are only useful for determining whether an intervention works or not. We will rely on different types of research evidence, such as quantitative, observational studies or qualitative studies, to tell us whether ideas or theories are useful or not. Whether research evidence is valid and reliable will depend on two factors: 1) was the research design appropriate to answer the research question? and 2) was the study well conducted? In this book, the strengths and weakness of cited research evidence will be discussed as far as possible, but all healthcare professionals need to be able to critically appraise research in order to make evidence-based decisions; there are many excellent resources available to help you develop this skill (see Further Reading). Finally, healthcare practice is often informed by guidelines produced by government or professional bodies. Critical appraisal skills will help you to understand whether or not a guideline is evidence-based and hence how or whether it should be implemented. Now let us consider how health psychology can help our clinical practice.

HEALTH PSYCHOLOGY AND HOW IT CAN HELP US AS NURSES, MIDWIVES OR HEALTH VISITORS

Psychology is the scientific study of people, the mind and behaviour. Health psychology is the application of psychological knowledge to the study of people's experience of health and illness. Health psychology research typically tries to predict or change how people will behave when they have a given illness, with the aim of improving physical and mental health outcomes and general **wellbeing**. These aims are shared by nurses, midwives and health visitors for their patients or clients.

Nurses, midwives and health visitors, of course, also conduct research. Combining what we know from nursing and health psychology enhances this research. This is especially the case in the field of behaviour change, which is important in the management of long-term conditions and health promotion – key areas of practice and research for many nurses, midwives and health visitors.

Specialist health psychologists may be part of the clinical team. Their role is to help people with the psychological and emotional aspects of illness or treatments and to support people with long-term conditions. This links closely with what nurses, midwives and health visitors do. At times we may need to provide very basic care, but a key part of our role is to ensure that patients or clients can self-manage in order to increase their independence, quality of life and their ability to cope in future. Health psychology theories and research, which predict how people may respond to illness and explain what is needed for people to manage their health, can help nurses, midwives and health visitors to do this.

THEORIES OF HEALTH AND BEHAVIOUR

To help you judge their value, as you read about theories of health and behaviour, bear in mind the information in Box 1.1 which summarises the properties of a good theory in social science.

Box 1.1: What makes a good theory in social science?

- Parsimony – explains a phenomenon in few terms as simply as possible
- Breadth – can be applied to a range of situations
- Accuracy – can produce testable predictions
- Falsifiable – it can be disproved
- Known **moderators** – specifies variables that tell you when relationships can and can't be expected
- Known **mediators** – specifies variables that tell you how or why a relationship occurs
- Fruitfulness – leads to new ideas

Most nurses, midwives and health visitors will be familiar with the biomedical and the biopsychosocial models of health.

The Biomedical Model

This **model**, or way of thinking about health, was dominant through most of the 20th century. It is a linear, unidirectional model where health is considered simply to be the absence of disease. Illness is seen as within the body, causing bodily symptoms that lead on to disability and restrictions on social life (Figure 1.1). The body can therefore be mended like a machine: removing part of a body or adding chemicals to it will lead to cure or avoidance of death.

However, the model was soon recognised as too simplistic and an alternative model – the biopsychosocial model – was proposed by psychiatrist George Engel (Engel, 1977) who advocated its use in research, teaching, and the provision of healthcare.

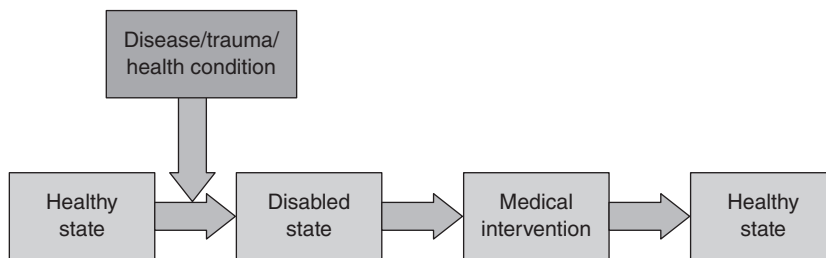


Figure 1.1 The Biomedical Model

Adapted from a figure produced by Paul Leimkuehler for the American Academy of Orthotists and Prosthetists.

The Biopsychosocial Model

This model recognises the contribution of biomedical, psychological and social factors to health (Figure 1.2). Biomedical factors include our genes, anatomy, physiology, bacteria and viruses; psychological factors may be our personality, behaviours and beliefs; social factors include social class, gender, ethnicity and socio-economic status.

How the Biopsychosocial Model Improves on the Biomedical Model

The biomedical model predicts an external cause of disease, but none may be found. For instance, in ‘**medically unexplained syndromes**’ such as irritable bowel syndrome, **chronic fatigue syndrome**, **fibromyalgia** and chronic low back pain, a person may experience very real and disabling symptoms but no medical reason can be identified. A biological cause for many severe mental illnesses has yet to be found.

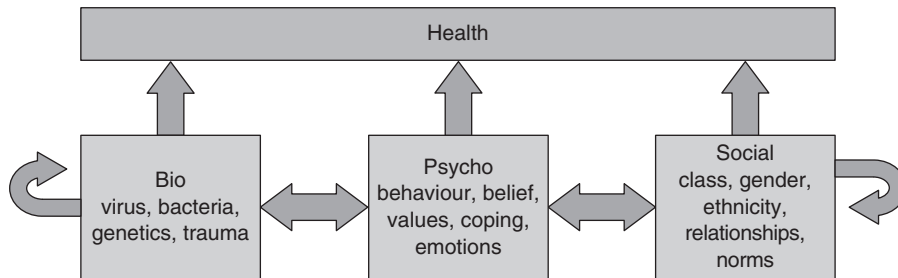


Figure 1.2 The Biopsychosocial Model: a holistic model

Adapted and reproduced with kind permission of the American Academy of Orthotists and Prosthetists.

The biopsychosocial model does not focus solely on cause, but recognises that beliefs and behaviours around illness can influence symptoms. We will look at this in more detail when we consider specific psychological theories.

The biomedical model also cannot explain individual variation in illness experience. For instance, two people with the same disease severity may report wide variation in their quality of life. The biopsychosocial model would predict that variation in psychological factors such as personality or **cognition**, or in social factors, such as available resources, are important. Compared to the other, one of the individuals may be more ‘resilient’ or able to distract themselves from symptoms, or they may have more family or practical support (someone to do the shopping) so that symptoms have less impact.

The ‘placebo effect’, where simply the expectation of cure can be beneficial, would fit with the biopsychosocial model which considers the impact of psychological factors on health (even if it does not explain them), but not the biomedical model, since no simple cause and effect process can be demonstrated.

The Biopsychopharmacosocial Model

Recently, a biopsychopharmacosocial model has been proposed (Clark and Clarke, 2014). This model builds on the biopsychosocial model to take into account how pharmaco-therapy can impact upon all aspects of patients’ lives due to, for instance, side effects, beliefs around medications (the patients’ and those of others) and the behaviours needed to adhere to a medication regimen. This model may be particularly relevant to those taking long-term daily medications such as people with mental illness or long-term conditions.

BEHAVIOUR CHANGE THEORIES IN HEALTH

The biopsychosocial model is therefore a general theory of how biomedical, psychological and social factors interact within health. Health psychology theories build on the biopsychosocial model by trying to predict or explain in more detail how specific biomedical, psychological and social factors interact to influence health or illness

behaviours and outcomes. Theories differ in terms of their emphasis on cognitions (beliefs), affect (emotions or feelings) or habits, or on change processes or maintenance of ongoing behaviours.

Health psychologist Susan Michie and colleagues (2014) have identified no less than 83 theories concerned with behaviour change and considered useful when developing interventions to change behaviour. Several of the included theories, such as the ‘Ecological Model for Preventing Type 2 Diabetes in Minority Youth’ (Burnet et al., 2002) and the ‘General Theory of Deviant Behaviour’ (Kaplan et al., 1982), focus on very specific conditions, populations or behaviours. It is probably more helpful here to focus on broader health psychology theories, which, as nurses, midwives or health visitors, we can apply to a range of conditions and associated health behaviours.

The three models discussed focus on changing individual behaviour; theories of societal behaviour change will be considered briefly in Chapter 4 in relation to governments’ or companies’ attempts to change population or group behaviour.

The Health Belief Model (Rosenstock, 1966; Becker, 1974)

The Health Belief Model (HBM) predicts that people make decisions about their behaviour based on a rational weighing up of perceived pros and cons or ‘costs and benefits analysis’. It is a ‘cognitive model’, which means that the role of beliefs is emphasised.

The HBM specifies the beliefs which predict how likely it is that someone will change their behaviour. These beliefs are:

- Perceived vulnerability – how ‘at risk’ a person feels
- Disease severity – how severe/unpleasant the person perceives a disease to be
- The costs of changing a behaviour – e.g. ‘I will feel stressed if I stop smoking’
- The benefits of changing a behaviour – e.g. ‘I will be able to wear my nice dress if I lose weight’
- Cues to action – triggers or prompts to change behaviour, either internal e.g. symptoms or external e.g. health advice from a nurse

Later developments of the HBM consider the influence of ‘self-efficacy’ (the person’s belief that they can change) and ‘health motivation’ (readiness to change). These factors involve the beliefs and influence of others so the HBM can now be termed a ‘social cognition model’ (see Box 1.2).

HBM Critical Appraisal and Evidence Base

The HBM predicts that if someone perceives a negative health outcome to be severe, sees themselves to be susceptible to it, considers the benefits of behaviours that reduce the likelihood of that outcome to be high, and perceives the barriers to adopting those behaviours to be low, then they will be likely to change their behaviour. If the model is correct, research evidence will show that these beliefs will predict actual behaviour.

In a systematic review, Carpenter (2010) found 18 studies, published between 1982 and 2007, which tested this in relation to treatment or health prevention behaviours. Carpenter focused on prospective longitudinal studies as an earlier similar review by

Harrison and colleagues (1992) suggested that retrospective studies may be biased since they tended to show significantly larger effect sizes than prospective studies. Carpenter's review found that beliefs around severity, benefits and barriers did predict the likelihood of future behaviour. Benefits and barriers were the strongest predictors; perceived susceptibility was a poor predictor. There were differences in effect for treatment versus health prevention behaviours and the length of time between measurement of beliefs and performance of behaviour appeared to moderate the effects. Carpenter proposes that more work is needed to identify the mediators and moderators between health beliefs and behaviour.

To determine whether the HBM is useful in healthcare practice we need to examine RCTs testing interventions informed by the model. Jones and colleagues (2014) identified 18 studies (16 RCTs; two before and after controlled trials, search conducted 2012), which tested the effect of HBM interventions on adherence to a range of health behaviours such as taking medications, following diets and making lifestyle changes. The quality of the included studies was rated by the authors as varying from high to low, although most of the studies did not report sufficient information for the authors to assess fully the risk of bias. The reviewers found that the majority of the studies (15/18) reported statistically significant improvements in adherence compared to control interventions.

Only six of the studies used all elements of the HBM. The interventions in the included studies mostly targeted beliefs around benefits, susceptibility and barriers. In contrast to Carpenter's review (2010), Jones and colleagues (2014) found no difference in effectiveness between interventions based on different beliefs. Carpenter's review included trials of any health behaviour whereas Jones et al.'s (2014) review only included interventions which addressed adherence to treatment; it is possible that the HBM, or elements of it, is better at predicting some kinds of behaviours than others. In addition, since few trials tested the full HBM it is possible that intervention success may be due to factors independent of the model, such as specific behaviour change techniques.

Evidence for the effectiveness of interventions informed by the HBM is therefore weak. However, there is evidence that the beliefs within the model can predict behaviour. As nurses, midwives and health visitors it will be useful for us to use this information to help understand why a particular patient may be finding it hard to make healthy choices. The importance of health beliefs is illustrated in the case example which relates health beliefs to the decision to take up breast cancer screening.



Case Example: Health beliefs and uptake of breast cancer screening

Jean is 50 years old and has been invited to attend for a mammography for the first time as part of a national breast cancer screening programme.

Jean's 'perceived vulnerability' is low; she thinks 'no one in my family has had this disease'. Her perception of 'disease severity' is high; she remembers 'my friend Vivien had breast cancer, chemotherapy was really horrible and the cancer could come back any time'.

(Continued)

(Continued)

Jean considers what would be involved if she accepted the invitation (her perceived costs); she thinks 'the procedure may be painful and I will have to take time off work'. She wonders if it is worth going for the mammogram (her perceived benefits); she thinks 'at least, if I do have breast cancer, it would be caught early and I may not have to have chemotherapy'.

After reading the leaflet that came with the invitation more fully and after talking to a colleague who has recently attended (cues to action), Jean decides she will go for her mammography.

Whether she actually attends may depend on how confident she is that she can organise time off work to have the procedure (self-efficacy).

Theory of Planned Behaviour (Ajzen, 1985, 1991; Ajzen and Madden, 1986) and Reasoned Action (Fishbein and Ajzen, 1975)

The Theory of Planned Behaviour (TPB) is a general theory of behaviour which has been very widely applied to health. It is a 'social cognition model' (see Box 1.2), so attitudes and beliefs of the individual and others are at its centre. It considers both change processes and maintenance behaviours.

It is developed from the Theory of Reasoned Action (TRA). Central to TRA is that intention to act is the best predictor of behaviour. Intentions are developed following an individual's evaluation of a behaviour and its expected outcomes. Their evaluation is influenced by their '**subjective norms**'. Subjective norms are the social pressures perceived by an individual as a result of their beliefs about what they think others think they should do. How much they want to do what others want is important too; social pressure will be higher if it is perceived as coming from respected or loved others. Figure 1.3 applies the TPB to stopping smoking.

The TPB adds the construct of 'perceived behavioural control' to the model. Perceived behavioural control is considered important to both behavioural intention and actual behaviour; it relates to the ease or difficulty with which an individual thinks they will be able to carry out a behaviour. As such, it is very similar to the concept of self-efficacy described in Box 1.2. Perceived behavioural control is informed by 'internal control factors', such as perceived or known skills, abilities, feeling informed, and by 'external control factors', such as perceived or known obstacles, and opportunities. Perceived internal and external control factors are derived from past experience. Figure 1.3 illustrates the TPB with an example of someone, whom the model would predict, is in a good position to stop smoking. It is possible to see that if any of the stated beliefs and attitudes were less positive the likelihood of stopping smoking would be reduced.

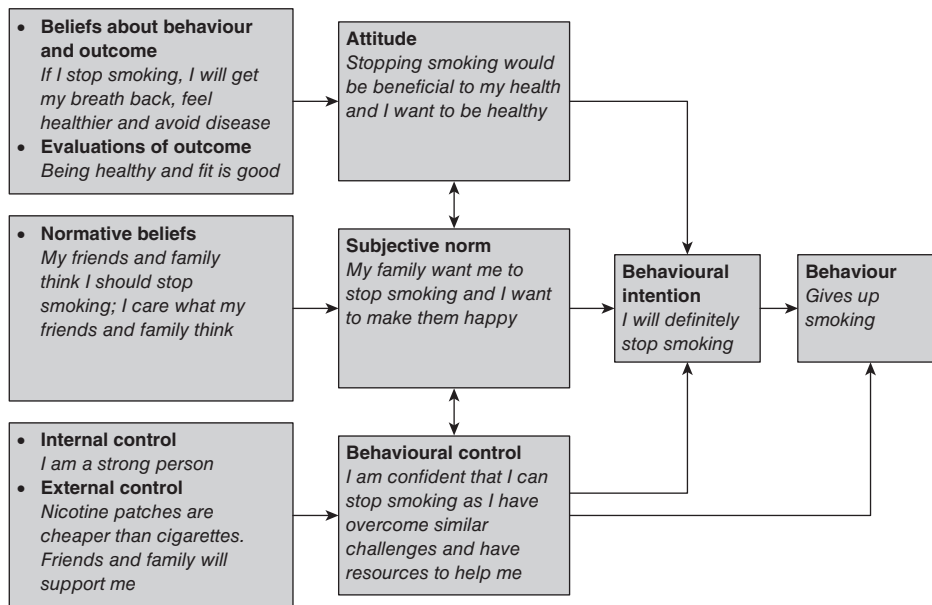


Figure 1.3 Theory of Planned Behaviour applied to stopping smoking (Ajzen, 1991)

TPB Critical Appraisal and Evidence Base

A systematic review by McEachan and colleagues (2011) identified 206 articles (search year 2010), including a range of study designs, which contained 237 independent empirical tests of the TPB. The strength of the review was that it included only prospective studies of all elements of the TPB in relation to a range of health or health risk behaviours. Various predictions of the model were supported: intention was the strongest predictor of prospective behaviour, demonstrating a medium to large effect; direct measures of attitudes and perceived behavioural control showed medium-sized relationships with behaviour; attitude was the strongest predictor of intention, followed by perceived behavioural control (direct) and then **social norms**; past behaviour showed medium to large correlations with behaviour and intention, and medium correlations with attitude and perceived behavioural control, and a small to medium relationship with social norms. Overall a meta-analysis indicated that the TPB explained 19.3 per cent of the variance in behaviour and 44.3 per cent of the variance in intention. This is a smaller number than an earlier slightly less rigorous meta-analysis found (Armitage and Conner, 2001), which had otherwise similar findings. These findings demonstrate that the TPB model is insufficient, as is any model, to fully explain behaviour change.

To address this McEachan and colleagues (2011) examined moderating factors and found that behaviour type moderated relationships among the model components,

for instance, physical activity and dietary behaviours were best predicted by the model. The mean age of the sample was also important in relationships and in specific behaviours. Study methodology factors such as length of follow-up and type of outcome measure were also moderators, with larger effects found for shorter follow-up time periods and for outcomes measured by self-report compared with an objective measure.

Overall, there is some evidence for the ability of the TPB to predict behaviour, but the picture is complicated as other factors, not in the model, are also important. The strength of the TPB, compared with the HBM, is that, instead of assuming that people act in rational and coherent ways, an element of irrationality is included within the evaluations element, social and environmental factors are considered through the inclusion of social norms, and the importance of past behaviour is accounted for as part of perceived behavioural control.

There is much less evidence concerning the effectiveness of interventions informed by the TPB to change health behaviour, perhaps because guidance on developing concrete intervention strategies from the abstract theory is vague (French et al., 2013). Darker and colleagues (2010) developed an intervention to promote walking in the general public which was designed to alter perceived behavioural control and create walking plans. They tested whether the intervention increased TPB measures concerning walking more, planning and objectively measured walking in an RCT of 130 adults. They found that the intervention increased perceived behavioural control, attitudes, intentions and objectively measured walking from 20 to 32 minutes a day post intervention and at 6 weeks follow up. This was a well-designed study, but more experimental research is needed to test whether interventions informed by the TPB are effective for behaviours other than walking and in populations other than the general public. In the meantime, the model can be used to help us to consider systematically the myriad factors that make behaviour change in our patients more or less likely.

Box 1.2: Social cognition models

Based on Social Cognition Theory (Bandura, 1977, 1986).

Behaviour is seen as governed by:

- Expectancies – situation outcome expectancy, behaviour may be dangerous; outcome expectancy, behaviour can reduce harm; self-efficacy expectancy, the person believes they can accomplish the desired behaviour
- Incentives – the consequences of the behaviour are important
- Social cognitions – beliefs about other people and the broader world

Stages of Change (Transtheoretical) Model: (Prochaska and DiClemente, 1983; Prochaska et al., 1992)

The Stages of Change Model (SCM) introduces the importance of 'readiness to change' to behaviour change models. It predicts that people at different stages of

readiness will face the same barriers to change and will therefore require intervention tailored to these. The stages described by the model are:

- Pre-contemplation – no intention to change; may not be aware of the need for change
- Contemplation – aware of a problem and considering changing
- Preparation or ‘action planning’ – making small changes or thinking about how to go about changing
- Action or ‘implementation’ – actively trying to change by carrying out new behaviours
- Maintenance – persisting with the new behaviour and trying not to relapse

Though originally developed in relation to smoking cessation, the model can be applied to a range of behaviours. It also predicts that people can relapse in terms of stages, for instance people who stop drinking alcohol or stop smoking (action stage) often relapse and may not consider stopping again (pre-contemplation) until they realise that the behaviour is a problem again (contemplation stage).

SCM Critical Appraisal and Evidence Base

The SCM appears intuitive; people clearly have different levels of readiness to change, which are likely to be associated with different beliefs and hence interventions should be tailored to affect the processes associated with moving to the next stage (or staying in the maintenance stage). If the SCM is correct, RCT evidence should show that stage-matched interventions are more effective than other interventions.

In a systematic search of a range of sources (search date May 2000), Bridle et al. (2005: abstract) identified 37 RCTs testing this. The RCTs targeted a range of health-related behaviours: smoking cessation, physical activity, dietary change, multiple lifestyle changes, screening mammography, treatment adherence in the context of mental illness, and preventing the uptake of unhealthy behaviours such as smoking and alcohol use. The methodological quality of trials was found to be variable, and, overall, the review authors found ‘limited evidence for the effectiveness of stage-based interventions as a basis for behaviour change or for facilitating stage progression, irrespective of whether those interventions were compared with other types of intervention or with no intervention or usual care controls’.

Why might this be the case? West (2005) has criticised the SCM for focusing on soft outcomes, such as transition between stages, in an absence of evidence that behaviour change actually occurs, and for lack of evidence to support the model’s assertion that the stages are discreet and that people move smoothly through stages through making coherent plans to do so. West also argues that the model neglects unconscious processes such as the role of reward and punishment on habits and health behaviour.

The SCM was originally devised as a descriptive device for the creation of appropriate interventions for behaviour change; it appears from the evidence that it does not work in terms of being able to predict actual behaviour change.

Nevertheless, the intuitive nature of the model means it may have value in helping patients to think about where they are on the journey to behaviour change and reminds us as clinicians that a ‘one size fits all’ approach to behaviour change is unlikely to be useful. The case example relates the stages of change model to the decision to lose weight.



Case Example: Stages of change and the decision to lose weight

Derek is 45 years old. His practice nurse has told him that he has an unhealthy **body mass index**; he needs to lose weight to stay healthy.

Before Derek saw the nurse, he had no idea that his weight was a problem (pre-contemplation); he thought ‘I have put on a few pounds, but that’s due to my age. It’s not so bad’.

Since the nurse suggested that his weight may cause him health problems in the long term, he has started to think about whether he ought to lose weight (contemplation); he thinks ‘perhaps I could start eating more healthily’.

Derek wonders what eating more healthily might involve and what he could do (action planning); he thinks ‘alcohol is very fattening, I could cut down’.

During the following week, Derek has three alcohol free days and limits his drinking to three beers instead of his usual four on Saturday night (implementation).

Arriving at the pub an hour later than usual and telling his wife his plan so that she can support him helps him to stick with his plan (maintenance).

HEALTH PSYCHOLOGY AND HOLISTIC CARE

As nurses, midwives and health visitors, we know we should be delivering ‘holistic care’.

All nurses must practise in a holistic, non-judgmental, caring and sensitive manner that avoids assumptions, supports social inclusion; recognises and respects individual choice; and acknowledges diversity. Where necessary, they must challenge inequality, discrimination and exclusion from access to care. (NMC – competencies for entry onto the register: www.nmc.org.uk/globalassets/sitedocuments/standards/nmc-standards-for-pre-registration-nursing-education.pdf, p. 13)

Holistic care is informed by the theory of ‘Holism’, the idea that the parts, or systems, of any whole cannot exist or be understood except in their relation to each other and to the whole. This can be contrasted with the concept of ‘dualism’ where a reality is considered to consist of two fundamental parts. How this applies to healthcare is illustrated in Figure 1.4, which shows dualism informing a simple biomedical model, where health and illness are seen as distinct, and holism informing more complex models such as the biopsychopharmacosocial model, where health and illness may overlap, influenced by all elements of the person.

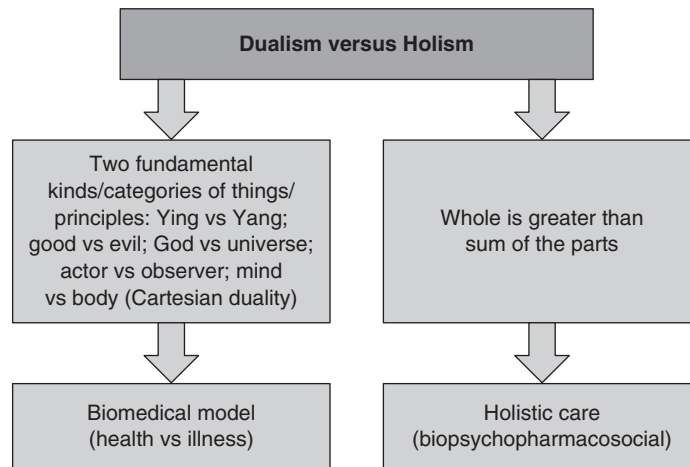


Figure 1.4 Dualism versus Holism

The NMC sums this up in its definition of holistic:

Considering the whole person; taking physical, social, economic, psychological, spiritual and all other relevant factors into consideration when assessing, planning and delivering care. (www.nmc.org.uk/globalassets/sitedocuments/standards/nmc-standards-for-pre-registration-nursing-education.pdf, p. 148)

Activity: Reflection

It is easy to see how one aspect of our being impacts on the others to contribute to our overall health or wellbeing and to agree that holistic care is a 'good thing' – so much so that our professional body calls it a competency. But how does this work in practice? Do we, as a society, care for patients in a holistic way? If you answered yes, the following sections may change your mind!

The Case of Physical Versus Mental Healthcare

You will immediately have spotted the dualistic nature of the title of this section! The reality is, in our society (and most others) physical and mental health are managed separately. The following research findings are presented as evidence:

Compared with the general population, people with schizophrenia or bipolar disorder are:

- 3 times more likely to die if they develop cancer (The Schizophrenia Commission 2012)
- 2–3 times more likely to have a long-term condition (Carney et al., 2006)
- 2 times more at risk of death from heart disease (Osby et al., 2001; Saha et al., 2007)

The mental health charity Rethink has called this ‘lethal discrimination’; its report of this name (Rethink, 2013) highlights that:

- People with severe mental illness (SMI) die, on average, 20 years earlier than the general population
- More than 40 per cent of tobacco is smoked by people with SMI, but they are less likely to receive quit support
- Less than 30 per cent of people with schizophrenia receive an annual physical health check
- There is an average weight gain of 13lbs in the first two months of taking antipsychotic medications, but 70 per cent of new starters in some areas of the UK receive no weight monitoring
- Healthcare professionals fail to take people with SMI seriously when they raise concerns about their physical health (this is known as ‘diagnostic overshadowing’)

Similarly disheartening facts are available around the management of the mental health of people with physical health problems (Tylee et al., 2012):

- Depression is increased in people with long-term conditions (there is evidence for this in respiratory, renal, cardiac and vascular conditions, in diabetes, epilepsy, Parkinson’s, HIV/AIDS and cancer).
- Depression co-morbid with a long-term condition is associated with worse outcome, including death. For instance, people with cardiovascular diseases are twice as likely to have another cardiac event or to die if they are depressed compared with someone who is not depressed (Celano and Huffman, 2011) and people with diabetes who experience poor psychological wellbeing have worse glycaemic control, health-related quality of life and mortality (Diabetes UK, 2010).
- Yet people with long-term conditions may not routinely receive psychological support; most are managed in primary care, but GPs and practice nurses report a lack of confidence in managing mental health (Barley et al., 2012a).



Activity: Reflection

What barriers, at societal and practitioner level, exist to the provision of holistic care? Consider the following barriers – do you agree and how might they be addressed?

- Knowledge about mental and physical health is compartmentalised: consider how health professional training is delivered, how research funding is allocated and how health services are commissioned
- Health professionals lack the resources and knowledge to address social problems
- IT sharing is limited across healthcare systems
- There is no way to systematically operationalise or measure holistic care
- No one has overall responsibility for ensuring that holistic care is delivered

As nurses, midwives and health visitors, depending on our role, we may have limited influence over how health services are delivered, but, in light of the above evidence for inadequate delivery of holistic care, we should all consider how to improve our individual practice and take personal responsibility for delivering holistic care. This is where health psychology can help. Our understanding of the biopsychosocial and biopsychopharmacosocial models reminds us to consider social, psychological, pharmacological and biomedical factors when assessing patients and planning, implementing and evaluating care. Health psychology, as we see in the models described above, goes further by identifying specific thoughts and behaviours that are important to health and, by defining them, allows us to test whether interventions which target them are helpful or not. Subsequent chapters will detail practical, evidence-based, psychological skills which will help us address these modifiable thoughts and behaviours to improve outcomes.

HEALTH PSYCHOLOGY AND PERSON-CENTRED CARE

The NMC states that all nurses:

must practise autonomously and be responsible and accountable for safe, compassionate, person-centred, evidence-based nursing that respects and maintains dignity and human rights. (NMC – generic standard for competence: www.nmc.org.uk/globalassets/sitedocuments/standards/nmc-standards-for-pre-registration-nursing-education.pdf, p. 13)

Person-centred care is defined as:

Care tailored to the individual needs and choices of the service user, taking into account diversity, culture, religion, spirituality, sexuality, gender, age, and disability. The principle is also applied to child-centred, family-centred and user-centred care. (NMC www.nmc.org.uk/globalassets/sitedocuments/standards/nmc-standards-for-pre-registration-nursing-education.pdf, p. 149)

Manley and colleagues (2011) suggest that we know when person-centred care is being delivered when the following are experienced or observed:

- Getting to know the patient as a person, his or her **values**, beliefs and aspirations, health and social care needs and preferences
- Enabling the patient to make decisions based on informed choices about what options and assistance are available
- **Shared decision-making** between patients and healthcare teams
- Providing information that is tailored to each person
- Supporting the person to assert his or her choices
- Ongoing evaluation to ascertain that care and services continue to be appropriate for each person

However, it is well acknowledged that achieving person-centred care can be challenging and difficult to sustain (Manley et al., 2011). By examining the models of health

and behaviour change developed by psychologists, we begin to understand why this may be the case. These models highlight the complexity of health and health behaviour change by detailing important thoughts, feelings and behaviours and how they interact. For instance, the models predict that a person's health-related behaviour is influenced by perceived costs and benefits, vulnerability, consequences, control and by motivations and intentions which interact in specific ways. Furthermore, all of these may be informed by past experience and/or perceived social norms and, since people's experience is ongoing, may change according to the person's present circumstances and their mood. When providing person-centred care in the ways described above, we are likely to be more successful if we take all of this into account.

CHAPTER SUMMARY

Key theories of health and behaviour change have been described and appraised and, where available, recent systematic review evidence of their effectiveness has been presented.

Support for the ability of the models to describe behaviour is often stronger than their ability to predict behaviour.

There is some RCT evidence that interventions informed by health psychology models may change behaviour, but how much evidence there is and its quality varies according to the specific behaviour and types of patients studied.

Health psychology models identify specific thoughts, feelings and behaviours and the ways in which they interact in health and illness.

Knowledge of the components of health psychology models allows us to test through research which are targets for effective behaviour change and care delivery and, in practice, helps us to assess patients more fully and to plan and implement evidence-based, holistic and person-centred care.

CONSOLIDATE YOUR LEARNING

✓ Activity: Quiz

(Answers can be found at the end of this book.)

1. Why is the randomised controlled trial (RCT) the best study design for determining the effectiveness of an intervention?
2. In systematic reviews, what is the difference between a finding of a lack of evidence and a finding of evidence of no effect?
3. What is meant when we say that the Health Belief Model (Rosenstock, 1966; Becker, 1974) is a 'cognitive' model?
4. According to the Theory of Planned Behaviour (Ajzen, 1985, 1991; Ajzen and Madden, 1986), what factors affect an individual's 'perceived behavioural control'?



Activity: Reflection

Using behaviour change theories in practice

Application of any model of health or health behaviour in full during your day-to-day practice may not be feasible (or desired given their limitations!), but think now about how knowledge of elements of the models may be useful to you:

- What factors might you consider when asking someone to take or change their medication or lifestyle?
- What might get in the way of behaviour change?
- What might help people to change their behaviour?
- Most of the evidence presented was developed in adults, how might the age of your patient be important?

FURTHER READING

Psychology in general: Walker, J., Payne, S., Jarrett, N. and Ley, T. (2012) *Psychology for Nurses and the Caring Professions* (Fourth edition). Maidenhead: Open University Press.
Health psychology: Ogden, J. (2012) *Health Psychology: A Textbook* (Fifth edition). Maidenhead: Open University Press. Or Marks, D.F., Murray, M., Evans, B. and Estacio, E.V. (2011) *Health Psychology: Theory, Research and Practice* (Third edition). London: Sage.
Critical appraisal and research methods: Moule, P. (2015) *Making Sense of Research in Nursing, Health and Social Care* (Fifth edition). London: Sage.

USEFUL WEBSITES

Evidence-based practice education, training and resources: Centre for Evidence-based medicine: www.cebm.net/

Database of high-quality systematic reviews and, in the Cochrane Handbook, which can be found on this site, information on how to conduct systematic reviews: www.cochranelibrary.com/